Motor Vehicle Division

40-1504A R01/09 www.azdot.gov

MEDICAL EXAMINER CERTIFICATE

Clear

Driver Name (first, middle, last, suffix)

I certify that I have examined this driver in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with the knowledge of the driving duties.

I find this person is qualified; and, if applicable, only when:

- ❒ Wearing corrective lenses
- ❒ Wearing a hearing aid
- ❒ Accompanied by a _____ waiver/exemption
- ❒ Driving within an exempt intracity zone
- ❒ Qualified by operation of 49 CFR 391.64
- ❒ Accompanied by a Skill Performance Evaluation Certificate (SPE)

The information I provided regarding this physical examination is true and complete. A complete examination form (with any attachments) embodies my findings completely and correctly, and is on file in my office.

Medical Examiner Name (print)			
Medical Examiner Signature		Date of Exam	This Medical Certificate Expires
❒ MD ❒ DO ❒ Chiropractor ❒ Physician's Assistant ❒ Registered Nurse Practitioner			
Medical License or Certificate Number	State	Phone ( )	

Driver Address		City	State	Zip
Driver License Number	State			
Driver Signature				